11.   Filing Claims

Payment can be made for Adult Care Home Personal Care (ACH/PC) and Non-Emergency Medically Necessary Transportation (NEMNT) that is provided according to Medicaid policies. Follow the procedures in this section to request payment for ACH/PC and/or NEMNT.

11.1   Who May File a Claim

You may file a claim for providing ACH/PC and/or NEMNT if you are enrolled with the Division of Medical Assistance (DMA) as an adult care home provider and the service was provided according to Medicaid policies.

Note: The provider number on the claim must be the provider number of the adult care home where the resident resided on the dates of service billed.

11.2   How Are Claims Submitted

To be paid by Medicaid, you must submit a claim to Electronic Data Systems (EDS) by mail on a UB-92 claim form or by electronic claims submission. UB-92 claim forms may be purchased at office supply stores. EDS' address for submitting claims is in Appendix B. A sample completed UB-92 claim form is in Appendix K and instructions for preparing the form are in Appendix L. Electronic claims submission is described further in Section 11.6.

11.3   What May Be Billed

The billing unit for both ACH/PC and NEMNT is one day. If the service is provided according to Medicaid policies and procedures and properly documented, the adult care home may bill for ACH/PC and/or NEMNT for:

- Each day that the resident is in the adult care home, beginning with the date of admission;

- Any days that the resident receives outpatient medical services or is treated in a hospital observation unit, but is not admitted;

- Each therapeutic leave day taken by the resident, not to exceed a total of 60 days in a calendar year; and

- The date of death, if the resident died at the adult care home.

The following are general requirements for what may be billed:

- You may not continue to bill for therapeutic leave days once a resident has informed you, either verbally or in writing, that he or she has decided not to return to your facility.

- The day that a resident is discharged to go to a hospital, nursing facility, ICF-MR, another adult care home, or private home must be included on the UB-92 claim; however, it is not a paid date of service.

- You may not bill for days that the resident is an inpatient in a hospital or other medical facility and receiving treatments paid for by Medicare or Medicaid.

- The day that a resident is discharged from a hospital, nursing facility, ICF-MR, or other adult care home and admitted to your adult care home is a billable date of service.

11.4 Payment Rates

ACH/PC and NEMNT are paid at fixed rates for each date of service. The payment rates are based on the estimated daily cost of providing these services. The current payment rates and codes for billing them are in Appendix I.

11.5 Getting Paid

Within one to three weeks of submitting a claim, you will receive a check for paid claims along with a computer-generated Remittance and Status Report, which is also called the "Remittance Advice" (RA). The RA shows the status of claims which were processed during the current cycle and those that are pending. See Section 12 for guidance on using the RA to track claims.

11.6 Who's Involved in Claims Processing

DMA and EDS have multiple roles in claims processing.

- **DMA** establishes which services are covered by the Medicaid program, the criteria for payment, and the payment rates. The following units within DMA have a role in claims processing:

    - **Provider Enrollment Unit** enrolls providers of services.

    - **Rate Setting Unit** establishes rates for Medicaid services.

    - **Adult Care Home Services Unit** establishes coverage criteria and limitations.

    - **Claims Analysis Unit** assists in resolving claims problems related to Medicaid eligibility.

    - **Medicaid Management Information System (MMIS) Unit** coordinates operation of the claims processing system with EDS.

    - **Program Integrity Unit** reviews claims data for signs of program abuse or fraud.

- **EDS** is responsible for processing Medicaid claims for payment under a contractual arrangement with DMA. EDS also assists providers with claims in a variety of ways:

    - **Provider Services Telephone Correspondents** answer questions about filing claims, payments, claims problems, obtaining forms, and coverage issues. This service is available Monday through Friday from 8:00 a.m. to 4:30 p.m. at the telephone number in Appendix B.

    - **Voice Inquiry System** is an automated telephone response system that can be used to inquire about Medicaid eligibility, status of claims, and the checkwrite schedule. Calls to the Voice Inquiry System must be made with a touch-tone telephone. Directions for using the Voice Inquiry System are in Appendix C.

    - **Provider Representatives** conduct provider training sessions and are available to assist individual providers with on-site visits. The telephone number for EDS' Provider Representatives is in Appendix B.

    - **Electronic Claims Submission (ECS)** allows providers to submit claims to EDS electronically by modem, magnetic tape, or diskette. Electronic claims are processed faster than paper claims so providers receive payments sooner. EDS supplies ECS software and

instructions for filing ECS claims to providers free of charge. ECS also automates claims tracking. ECS Analysts are available to answer questions about ECS Monday through Friday from 8:00 a.m. to 4:30 p.m. at the telephone number in Appendix B.

♦ Electronic Funds Transfer (EFT) enables providers to receive Medicaid payments through an automatic bank deposit while continuing to receive a Remittance and Status Report at their current mailing address. Utilizing EFT eliminates the possibility of checks being delayed or lost in the mail. An EFT Representative is available to answer questions Monday through Friday from 8:00 a.m. to 4:30 p.m. at the telephone number in Appendix B.

11.7   Time Limits

Your claim for Medicaid reimbursement must be received by EDS within 365 days of the date of service. You must maintain the original or a copy of each paper and/or electronic claim submitted to EDS for a period of five (5) years from the date of the service.

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